DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

acceptable

PRINTED: 01/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #3	44A120	A. BUILDING _____ B. WING _____	C 01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN M REED NURSING HOME	124 JOHN REED HOME RD LIMESTONE, TN 37681

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An on-site investigation of complaint #29188 and #29164 was conducted on January 17-20, 2012. Based on the investigation, the facility was cited Immediate Jeopardy (a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death) for Physical Environment for Health at F-454 and for Life Safety from Fire at K-38. The Immediate Jeopardy for tag F-454 and K-38 was effective January 17, 2012 and removed January 17, 2012 after the facility provided corrective action to ensure safe exit from the facility for three of eight exit doors in case of emergency. The Immediate Jeopardy tags were lowered in scope and severity from a "K" to an "E" level. A partial extended survey was conducted on January 17, 2012.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157	F- 157 The corrective action that could be accomplished for resident #17 cannot be accomplished due to her death on 1-20 - 2012. To identify other residents having the potential to be affected by the deficient practice the following corrective action will be taken: As residents are admitted, re-admitted a skin assessment will be done, by the Assessment Nurse or LPN/Charge Nurse, or as residents are assessed through the weekly skin assessments(see new form attached including notification to physician and family) by the Assessment Nurse or LPN/Charge Nurse, or if a report of a decline of the pressure ulcer comes on the 24 hour report from the CNA or a provider of service ie, Hospice verbally to the LPN/Charge Nurse. The currently used 24 hour report will be used to report any skin changes by the in house staff. This 24 hour	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Reed | TITLE: Administrator | (X5) DATE: 2-15-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to notify the Primary Physician or the Family Nurse Practitioner of a decline in a pressure ulcer for one resident (#17) of eight residents reviewed with pressure ulcers. The findings included: Resident #17 was admitted to the facility on July 18, 2008, and readmitted after a hospital stay on January 27, 2011, with diagnoses including Dementia with Behavioral Disturbances, Depressive Disorder, Senile Dementia, Anemia, Venous Thrombosis, Osteoporosis, Hypertension, and Chronic Kidney Disease. Medical record review revealed the resident was	F 157	report is used from one shift to the other for the Nursing Staff, both CNA's and LPN/Charge Nurses, writing down immediately as skin problems are found and is reported to each Nurse on that shift and to on coming Nursing staff. The LPN/Charge Nurse will immediately assess the resident herself, call Wound Doctor, Medical Director or Nurse Practitioner. LPN/Charge Nurse will call family. LPN/Charge Nurse then will document orders on the treatment log. The measure that will be put into place to ensure that notification to proper medical providers is done will be the following: A new Admission and Weekly Skin Assessment Form, see attached, will include notification to Dr. and Family, put into effect 2-17-2012. The LPN/Charge Nurses will be inserviced on 2-9-2102 by the Asst .DON of the importance of taking information from an CNA's from the 24 hour report or ie a verbal Hospice concern of skin integrity and doing the assessment herself and reporting to Med. Doctor or Wound Doctor or to the Nurse Practitioner and family member of any new or change in pressure ulcers. Beginning 2-17-2012 The DON will be given these Assessment forms weekly from the Nursing Secretary to audit the skin assessments and if the documentation was made to the Doctor or family. She will pick one patient per week starting on 2-17-2012 to check herself visually for accuracy and if the Physician or Family was notified. She will then take this information to monthly	

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F 157	Continued From page 2 admitted to Hospice Care on May 19, 2011, for diagnosis of Severe Progressive Dementia. Medical record review of a Weekly Skin Assessment dated November 16, 2011, revealed "...small open area to buttocks...Dermagran to area on buttock q (every) day et (and) PRN (as needed) until healed...Progress: healing..." Medical record review of a Weekly Skin Assessment dated January 4, 2012, revealed "...Coccyx Stage II (pressure ulcer)...red..." Medical record review of a Weekly Skin Assessment dated January 11, 2012, revealed "...coccyx Stage I...red..." Medical record review of two Hospice Certified Nursing Assistant (CNA) notes dated January 17, 2012, revealed "...bottom is worse...reported to (name) LPN (Licensed Practical Nurse)..." Medical record review of the Nurse's Notes, Weekly Skin Assessments, and Physician Orders revealed no documentation the Primary Physician or the Family Nurse Practitioner (FNP) had been notified of the decline of the pressure ulcer. Medical record review of a Weekly Skin Assessment dated January 18, 2012, revealed "...Coccyx Stage I...redden (misspelled)..." Observation on January 19, 2012, at 7:40 a.m., with two Hospice CNA's revealed the resident in bed on a specialty mattress and the two Hospice CNA's providing a bath. Continued observation revealed a pressure ulcer on the coccyx surrounded by a red area approximately 6 centimeters (cm) in diameter. Continued observation revealed within the red area was an oblong blue-purplish colored (unstageable) area	F 157	QA (Adm, DON and Asst. DON) to see if further education is required to disciplinary measures should be taken to help this not to recur. The Quarterly QA (DON, Asst. DON, ADM and Medical Director) will address these pressure ulcers and how they are reported and treated. .	F157 2-17-12

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F 157	Continued From page 3 approximately 4.5 cm in size. Interview with the two Hospice CNA's at the time of the observation revealed the area had been reported to (name) LPN (#3) on January 17, 2012. Interview with LPN #3 on January 20, 2012, at 8:00 a.m., confirmed the Hospice CNAs had reported the worsening pressure ulcer to LPN #3. continued interview confirmed the Primary Physician or the FNP had not been notified of the worsening pressure ulcer.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and interview, the facility failed to ensure residents were assessed for safe self administration of medications for one (#10) of eighteen residents reviewed. The findings included: Medical record review of the January 2012 monthly orders revealed resident #10 had a physician's order for Albuterol aerosol breathing treatments to be given every four hours. Medical record review revealed no physician's order for the resident to self administer.	F 176	F- 176 The corrective action that will be accomplished for the resident #10 who was found to be affected by the deficient practice will be: The resident was assessed on 2-2-2012 by the DON to determine if the practice is safe and then call the Medical Director for an order and then place on the treatment sheet for implementation. If the assessment finds the resident unable to do the self medication the nurse will do the treatment and remain with resident until treatment is complete. Resident #10 was found safe to self administer her nebulizer treatment and is doing well. To identify other residents having the potential to be affected by the same deficient practice: the DON identified all current residents receiving breathing treatments through the treatment log and an assessment was done, 2-2-2012, by the DON who will be responsible to determine if the ability to self administration is safe or not. She will do these assessments upon Admission for the residents that have an order to self	

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F 176	Continued From page 4 Observation on January 17, 2012 at 6:02 p.m. revealed resident #10 up in a wheelchair in own room receiving a breathing treatment. The resident said the nurse had just been in her room and started the treatment. The resident stated, "The nurses always start the treatment and I take it off when it runs dry." Observation on January 17, 2011 at 6:12 p.m. revealed the nurse pushed the medication cart up the hall without stopping to check on the resident. Observation on January 18, 2012 at 8:50 a.m. revealed the resident in own room, sitting in bed with the Albuterol aerosol breathing treatment on. The resident said the nurse was just in and started the treatment. Interview on January 18, 2012 at 9:12 a.m. with Registered Nurse (RN #1) at nurse station #2 verifed the resident was not assessed for self administration of medication and there was no doctors order for self administration of the breathing treatment. Interview with the Assistant Director of Nursing (ADON) on January 18, 2012 at 9:50 a.m., outside the Director of Nursing office, revealed the facility does not have a policy that addresses self administration of medications but it was facility practice to "Stay with the resident while getting breathing treatments."	F 176	administer and will be done on readmission and status change, being notified of status change through the 24 hour report from the Nursing staff. Facility will put into a place a policy and procedure for Self Administration of Medications and an Assessment Form to use. (Attached) Inservice on 2-9-2012 on the Policy and Assessment Form will be given by Asst. DON to Nursing Staff. A copy of the Self Adm. Assessments will be given to the Care Plan Co ordinator to be Care Planned.and put in resident's chart. The DON will complete herself all assessments to ensure that the deficient practice does not recur. DON will be given a list monthly by the Nursing Secretary to do assessments herself residents who are on breathing treatments to see if the policy is being adhered to and this does not recur She will take these assessments to monthly QA (Adm., DON And Asst. DON) to see if assessments are appropriate. From the monthly QA to the quarterly QA of which the Medical Director is in attendance this information will be discussed by the DON.	F176 2-9-12
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

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F 241	Continued From page 5 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and interview, the facility failed to ensure eight (#'s 5, 7, 19, 21, 20, 13, 22, 6) residents at one dining observation were treated with dignity during the meal service. The findings included: Review of the facility policy entitled "Resident Meal Service" revealed, "Pass trays out to one table at a time. Feed residents at the same table at the same time. When feeding residents it must be done face to face." Observation on January 17, 2012 at 5:10 p.m. revealed six residents, (#'s 5, 22, 13, 7, 19, 21) in the dining room sitting at a restorative dining table (circular tables used when feeding residents). Residents #20 and another resident were sitting at a table next to the restorative table. Observation revealed the other resident already had the dinner meal at 5:10 p.m. and was feeding self. Resident #20 sat at the same table, to the left of the other resident, facing the wall with the back to the whole dining room, watching the other resident eat. Resident #20 received the meal at 5:17 p.m., and at this time, the other resident left the table. Observation revealed resident #20 attempted to feed self with shaking movements. After several unsuccessful attempts to feed self, the resident stood up from the wheelchair. At	F 241	F – 241 The corrective action that will be accomplished for resident's #5, 7,19, 21, 20, 13, 22, & 6. Residents #5,22,13,7,19,&21 who are all seated at a round restorative dining table will be separated on 2-6-2012 by separating the round table into two tables., allowing them to be served at the same time. Trays will be passed out one table at a time. On 2-10-2012 the Dietary Department will be given names of residents who will be assigned seating at what table to enable them to have the trays ready for the same table for the same resident at the same time. Residents will be fed at the same table at the same time face to face by the CNA's or Nursing staff. Resident #7 was transferred from his wheelchair to a dining room chair on 2-8-2012 to help him remain in the dining room to give the staff an opportunity to feed him and encourage him to eat. He will be offered substitutes if he refuses what is on the menu for that meal. Containers will be put on the feeders tables to provide condiments preventing too much distraction in getting up from feeding to get a needed condiment. Resident #13 will be moved on 2-6-2012 to the end of a table and facing the table, placing something in her hand if possible to help prevent her grabbing at other residents and possibly keeping the noise to a minimum. The Asst. DON had an informal verbal inservice on 2-6-2012 with the	

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F 241	Continued From page 6 5:24 p.m. a Certified Nursing Assistant (CNA) came into the dining room, sat beside the resident and encouraged food intake. Observation at 5:15 p.m. revealed resident #7 was the first resident at the restorative table to receive a tray. CNA #1 placed the dinner meal in front of the resident and offered the resident "a bite of food". The resident said "not hungry". At 5:17 p.m. resident #7 slowly rolled self out of the dining room. Observations revealed no other CNAs attempted to feed or encourage the resident to eat, no substitutes were offered, and no staff attempted to bring the resident back to the table to encourage food intake. Observation at 5:16 p.m. revealed resident #19 was served the dinner meal. CNA #1 was observed standing to the right side of the resident, leaning inward, feeding the resident. CNA #1, who fed resident #19 was observed many times to get up to retrieve items, leaving resident #19 waiting to be fed. Observations at 5:17 p.m. revealed resident #21 was served the dinner meal. CNA #2 retrieved a chair and sat beside the resident to assist in feeding. At 5:18 p.m. CNA #1 who was feeding resident #19 went to retrieve a chair. CNA #1 said, "Didn't think about sitting down until I saw the other CNA." Observation at 5:17 p.m. revealed residents #'s 5, 13, 22, had not received their trays. Resident #5 (who was in a wheelchair) wheeled self away from the table saying "Have to go to bathroom, want a drink of water." The resident was returned to the table by a CNA. At 5:30 p.m. resident #5	F 241	Nursing staff and will have a formal inervice on 2-9-2012 to help accomplish this endeavor. Resident #6 will continue to be monitored to check her clothing protector to keep it clean. Resident #20 was assessed for special adaptive feeding utensils to possibly help with the shaking movements. She is currently being given finger foods. She will also be encouraged to sit at the table longer with offered encouragement from the CNA's. The assessment was done on 2-8-2012 by OT and they confirmed that finger foods were the best route to take. Since all residents have the potential to be affected by the deficient practice the corrective action will be: Trays will be served to one set of feeders at a time and one table at a time. Having tray set up and condiments offered before moving on to another table. Encouragements, offering of substitutions, and keeping residents awake and alert will be encouraged from the CNA's. CNA's will also monitor residents for unclean clothing protectors, leaving and returning to the table. Feeding the residents face to face seated in a chair. CNA's will also observe the noise level and remove or redirect if possible. The Asst. DON will provide an training inservice on 2-9-2012, any who aren't in attendance will be have material mailed to them on 2-9-2012 cover letter attached, with all CNA's on the tray delivery and seating system, encouragement, offering	

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F 241	Continued From page 7 had not received a tray. Four other residents at the restorative table were now being fed. At 5:31 p.m. resident #5's tray was placed on the table. At 5:33 p.m. the resident was given a glass of water. At 5:40 p.m. no one had offered to assist the resident, the tray remained on the table, the plate remained covered. Observation revealed at 5:45 p.m., 14 minutes after resident #5's tray was served, and thirty minutes after the first resident at the restorative table was served, the resident was offered the meal and was assisted by CNA #3. Resident #22 had received their tray at 5:20 p.m. and resident #13 was served at 5:25 p.m. Observation revealed resident #13 was seated in a reclined geri-chair with the head of the chair against the restorative table. The resident was positioned next to resident #22. Resident #13 was observed to make non-stop sounds and continuously reach out to resident #22 and the CNA feeding resident #22 while both residents were being fed. Observation on January 17, 2012 at 5:35-5:45 p.m. revealed another random resident sitting asleep at a table by the kitchen door. At 5:45 p.m. the resident woke up and wheeled self out of the dining room. The resident's ham, roll and jello on the dinner plate were untouched. No one attempted to encourage the resident to eat. Interviews with CNAs in the dining room on January 17, 2012 at 5:40 p.m. revealed trays are not passed to all residents at one table at a time and residents sit and watch other residents eat while waiting on their meal.	F 241	substitutions, monitoring of residents with the possibility of special needs, ie clean clothing protections or special feeding assistance, noise and touch control. At the time of hire the CNA's will have this included in their check off sheet to make sure that are aware of our procedures. The Asst. DON will do a weekly observation audit sheet of the dining room(starting 2-13-2012) tray delivery and set up with feeding service;(see attached Dining Room Observation Report) reporting to the DON fo monthly (Adm, DON and Asst. DON) QA to determine the need for any further training, changes or additions that might be needed. The Asst. DON will take this information to quarterly QA of which the Medical Director is in attendance for any suggestions he might have.	F 241 2-10-12

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F 241	Continued From page 8 Medical record review for Resident #6 documented an admission date of March 9, 2010 with diagnoses that included Idiopathic Scoliosis, Brain Injury, Dysphagia, Osteoporosis, Retention of Urine and Cardiomegaly. Review of the quarterly Minimum Data Set (MDS) dated November 30, 2011, assessed Resident #6 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15 (no cognitive impairment); independent with eating requiring staff set-up help only; and with functional limitation impairment on both sides for upper and lower extremities. Observation on 1/17/2012 at 5:50 p.m. revealed resident #6 seated in a wheelchair with a seat belt at a table in the dining room. Resident #6 leaned sharply to the right feeding self without assistance from staff. The resident was observed coughing and had spit up chewed food and liquid on the clothing protector. No staff approached the resident or assisted to clean up or change the clothing protector. Resident #6 completed the meal with the soiled clothing protector in place in view of other residents eating their meals.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	F - 280 The corrective action that will be accomplished for Resident #3 who was found to be affected by the deficient practice is: The Care Plan has been updated as of 1-31-21012 with the hospital re admission 1-2-2012 information. Since all the resident's have the potential to be affected by the same deficient practice the facility will put into place and inservice program for the LPN/Charge Nurses, given by the Asst. DON on 2-9-2012(any who are not in attendance will have written material	

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F 280	Continued From page 9 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to update a care plan for one resident (#3) of twenty-three residents reviewed. The findings included: Resident #3 was re-admitted to the facility on October 20, 2011, following repair of Right Femur Fracture, with diagnoses including Dementia, Diabetes Mellitus Type II (DM II), Osteoporosis, and Right Femur Fracture. Medical record review of the Minimum Data Set (MDS) dated November 16, 2011, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15 (no cognitive impairment); required total assistance with transfers and locomotion on the unit; did not ambulate; had limited range of motion with one lower extremity; did not have any pressure ulcers and was at risk for developing pressure ulcers.	F 280	mailed to them on 2-9-2012 by Asst. DON) on the paper procedure to admit or re-admit residents with the proper paper work procedure being followed to get the information to the Care Plan. When the DON signs off weekly on the Care Plans she will scan for documentation of hospital return information to ensure the deficient practice will not recur. The Nursing Secretary will give a Hospital Re-Admission Check(see attached) weekly to the DON obtained by her through the daily census to have when she signed off weekly on the Care Plans to verify that all hospital returns are care planned. The MDS Co-Ordinator on 1-25-2012 audited all care plans to verity that they were updated with all hospital returns reflecting patient current needs. The MDS Coordinator is responsible for collecting information from the chart and putting it on the care plan and the DON has always signed off on these weekly but will now use the Hospital Re-Admission Checklist to verify all hospital returns are care planned. The DON will take these results to the monthly QA(DON, Asst DON, ADM)starting with the 3-2012 meeting, which will report activity for 2-2102, to report of accuracy of Care Plans.	F 280 2-9-12

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F 280	Continued From page 10 Medical record review of the Care Area Assessment (CAAs) dated November 16, 2011, revealed, "...All information can be found in the residents chart dated 11/16/2011... " Medical record review of the Care Plan dated November 16, 2011, and last reviewed December 5, 2011, revealed, "...Resident has diabetic condition...Monitor feet closely for redness, breakdown, long toenails, etc (et cetera)...Resident will use a cane/walker while ambulating in...room, and a wheelchair for locomotion outside of...room...Resident is at risk of altered nutritional status...Current weight as of 11/16/2011 is 174.1 lbs (pounds)...Resident has blood blister to left heel. Apply treatment as ordered...Resident is at risk for skin breakdown related to impaired mobility related to right hip fracture...Assess skin Q (every) week...Document on Skin Assessment..." Medical record review of the Interdisciplinary Notes dated December 14, 2011, at 11:30 p.m., revealed the resident was sent to the hospital for evaluation and treatment of mental status changes. Medical record review of the Physician Admission Orders dated January 2, 2012, revealed, "...Diagnosis: UTI (Urinary Tract Infection), DM II, HTN (Hypertension), Blind, Anemia, Dementia...Admitted to (named hospital) 12/15/11 (with) AMS (Altered Mental Status). Found to have UTI E. Coli (Escherichia coli), Pseudo A (Pseudomonas aeruginosa) UTI. Treated (with) Doripenem (antibiotic) & (and) finished IV ABX (intravenous antibiotics) on 1/1/12...Waffle boots both feet..."	F 280		

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F 280	Continued From page 11 Medical record review of the Resident Assessment Mandatory Hospital Return Form dated January 2, 2012, revealed the resident returned to the facility with non-weight bearing status; dependent on staff for bed mobility, transfer, dressing, toileting, and bathing; occasionally incontinent of bowel; and the skin assessment indicated the resident had pinpoint open areas to both upper thighs, open area and redness to the upper left back, surgical scar to right hip, bruising to both arms, and no blood blister to the left heel (as indicated on the care plan dated November 16, 2011). Medical record review of the Dietary Progress Notes dated January 6, 2012, revealed, "Resident admitted to hospital on 12/14 & returned to facility on 1-2-12 (with) Dx (diagnosis) Altered Mental Status & UTI...Wt (weight) on hosp. (hospital) return 156.9 lbs., 5.7 % (percent) loss in past month, 15 % loss in past 2 months. Returned (with) pinpoint open areas on upper legs & open area/redness on left side of back..." Interviews with Licensed Practical Nurse (LPN) #3 on January 18, 2012, at 12:35 p.m., in the elevator, and 1:25 p.m., in the station 3 hallway, and with the MDS Coordinator at 3:05 p.m., in the Atrium, confirmed the resident was independent with most activities and cognitively intact before fracturing the right hip in October, 2011. Further interviews confirmed the resident had been declining in medical condition and abilities with the hip fracture, recurrent UTIs, decreased mobility, and an approximate two week hospitalization.	F 280		

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F 280	Continued From page 12 Observation of the resident and interviews with Certified Nursing Assistants (CNAs) #12 and #13 on January 18, 2012, at 3:50 p.m., in the resident's room, revealed the resident was lying in bed with waffle boots on, and both heels protruding through the opening in the boots with the heels lying on the mattress. Further interviews confirmed, since fracturing the hip, the resident was no longer able to stand or walk due to contracted legs, and the resident's condition had declined. Observation and interview with LPN #2, completing a skin assessment for the resident, on January 19, 2012, at 9:55 a.m., in the resident's room, confirmed the right heel had a 3.0 cm (centimeter) by 3.8 cm area to the right heel, described as a black and purple area with another area which was a smaller dark purple, raised area measuring 1.1 cm x 0.9 cm, and the tissue surrounding the heel area was "mushy...pink and red..." Further interview confirmed the resident had an unstageable pressure ulcer on the right heel and no blister on the left heel. Medical record review and interview with the Assistant Director of Nursing (ADON) on January 20, 2012, at 8:40 a.m., in the Atrium, confirmed resident #3 had a two week hospitalization, development of new medical conditions, and had experienced a significant decline in condition. Further interview confirmed the resident's care plan had not been updated since returning from the hospital January 2, 2012, to reflect the resident's recent decline in medical condition, weight loss, hospitalization, use of waffle boots, inability to ambulate independently, and the care	F 280		

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F 280	Continued From page 13 plan did not reflect the resident's current condition.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to provide care and services to prevent the development of or promote healing of pressure ulcers by failing to ensure physician's orders were followed for two (Resident #13 and #15), failing to ensure care plan interventions were consistently and correctly implemented for two (Resident #13 and #16), failing to ensure skin assessments were accurate and complete for the development of treatments and interventions for four (Resident #3, #13, #16, #17) and failing to ensure pressure ulcer risk was reassessed upon readmission for one (Resident #3) of eight residents reviewed with pressure ulcers. The facility's failure to ensure physician's orders were followed for daily wound care, failure to ensure the consistent implementation of heel protectors, failure to provide a pressure relieving	F 314	F - 314 The corrective actions will be accomplished for residents #3, 13, 15, 16, & 17 are as follows: Resident #13 Doctor ordered treatments have been e done and documented on the treatment sheets in the timely manner 1-18-2012 by the Treatment Nurse Charge Nurse/LPN as Doctored ordered. The heel protectors have been placed on the resident appropriately by the CAN's, on 1-18-2012. The weekly assessment has been done correctly on 1-18-2012 by the Assessment Nurse/LPN or charge Nurse and the wound has been correctly staged. Resident #3 will continue to have the waffle boots on in the correct position. The weekly skin assessment will be done correctly by the Assessment Nurse/LPN or Charge Nurse and the wound will be correctly staged. The Care Plan will be updated in accordance with any change or re-admission from the hospital noting any change in condition. Resident #15 has expired since survey date. Resident #16 The air mattress has been set on the proper setting on 1-20-2012 according to her weight at all times. Mfg. recommendations have been received and are being followed. The Asst. DON received the Mfg. instructions and thus instructed her Nursing staff of the proper way to set the mattress on 1-20-2012 and will give again on 2-9-2012. See copy attached and will mail to all who did not attend on 2-9-2102. The LP/Charge have these treatments, boots, air mattress etc on the MAR and must sign	

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F 314	Continued From page 14 mattress at the appropriate firmness for the resident's weight resulted in HARM to Resident #13 due to the right foot pressure ulcer declining from a Stage 2 to a Stage 3; and the facility's failure to reassess pressure ulcer risk and provide accurate and complete weekly skin assessments resulted in HARM to Resident #3 who developed a deep tissue injury to the heel that was unidentified by the facility. The findings included: Medical record review for Resident #13 documented an admission date of November 9, 2010 with diagnoses that included Alzheimer's Disease, Dementia, Transient Ischemic Attacks, Hypertension, Hypokalemia, Hypothyroidism and Gastroesophageal Reflux Disease. Review of the annual Minimum Data Set (MDS) dated November 8, 2011 assessed Resident #13 as total dependence on staff for transfers and locomotion on and off the unit; unable to ambulate; had limited range of motion with upper and lower extremities on both sides; was at risk for developing pressure ulcers; had skin and ulcer treatments of a pressure relieving device for the bed and chair, turning/repositioning program, nutrition or hydration intervention to manage skin problems, ulcer care and the application of dressings to feet; and had one venous or arterial ulcer present. Review of the current care plan developed November 9, 2011 identified the problem, "...Resident is at risk for skin breakdown due to bowel and bladder incontinent episodes, having splints to BLE's (bilateral lower extremities)	F 314	off q Shift for proper placement. Resident #17 the corrective action that could have been for this resident can not be done due to her death on 1-20-21012. To identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: an initial admission Skin Assessment will be performed by the Assessment Nurse then a weekly or re-admission from the hospital or any communication concerning the skin integrity of any resident a skin assessment will be done by the Assessment Nurse or LPN/Charge Nurse. This will inform the DON who sees these assessments weekly who has a new skin breakdown or if any have worsened or have gotten better. The LPN/Charge Nurse will then call the Doctor if needed for the treatment procedure and it can be put on the treatment log and treatment can begin. The LPN/Charge will then call the family. The Asst DON and Wound Doctor will inservice on 2-9-2102(copy of inservice attached and those who did not attend will have information mailed to them on 2-9-2012 cover letter attached), to all Licensed Nurses in facility on the complete Assessment procedure from initial Assessment to actual treatment. The Asst DON will inservice on 2-9-2012(see attached copy of inservice material and the cover letter)to the Nursing staff on the importance of communication between CNA's or outside providers of service to the LPN/Charge Nurses concerning changes in skin integrity of the residents. Including in this in service the accuracy of skin	

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F 314	Continued From page 15 applied at hs (hour of sleep), history of resolved ulcers, having an arterial ulcer, and impaired mobility related to Alzheimer's..." Approaches developed to address the risk for skin breakdown included, "...Use heel protectors while in bed...Apply treatment to arterial ulcer as ordered by (named wound care physician)..." During an interview in Resident #13's room on January 18, 2012 at 3:20 p.m., Licensed Practical Nurse (LPN) #2 stated that when the right foot wound was first identified, it was thought to be an arterial wound, but was reassessed as a pressure ulcer. Review of the physician's orders for January 2012 documented, "...MUPIROCIN OIN (ointment)...apply TOPICALLY TO WOUND BED ON FOOT Daily...SANTYL OIN...TOPICALLY TO WOUND BED ON FOOT Daily..." Review of the "ADMISSION AND WEEKLY SKIN ASSESSMENT" dated January 11, 2012, documented the wound location as "® (right) outer aspect of arch of foot" with the wound Stage assessed as Stage II (two) (Stage two pressure ulcers are "...partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough..."). Review of the Treatment Record for January 2012 for Resident #13 revealed no wound care treatment was documented for January 12 or January 17, 2012. Observation in Resident #13's room on January 18, 2012 beginning at 2:20 p.m., revealed the resident in a low bed with a pressure relieving	F 314	assessments. the correct positioning of waffle boots or heel protectors by the Nursing Staff, also the importance of following doctors order for wound care in a times manner. The LPN/Charge Nurse will have the responsibility of checking these waffle boots and heel protectors by signing off on the MAR Q shift if they are on and on correctly. The DON will be given all Skin Assessments starting 2-10-2012 and she will have the responsibility of reviewing the Skin Assessment herself for accuracy with one resident per week. Sshe will then sign off on the Skin Assessment itself for accuracy.. She will then decide if further education is needed or if disciplinary action is necessary. This will be a monthly Quality Improvement endeavor to be given to Administrator to monitor going to the quarterly QA for the Medical Director who attends along with the DON and Asst. DON and ADM. to audit for any additional information or suggestions for improvement. The Braden Scale has always been used upon admission but now will be used admission, and quarterly and will be done by the Assessment Nurse and will be inserviced by the Asst. DON on 2-9-2012(copy attached and all not in attendance will be mailed information on 2-9-2012 also a copy of cover letter) and the assessment done by 2-11-2012.	F 314 2-11-12

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F 314	Continued From page 16 mattress. Resident #13 was lying on back. Certified Nursing Assistant (CNA) #10 repositioned the resident onto the left side to prepare for wound care and dressing change. The resident had socks on both feet without heel protectors. The CNA removed the resident's socks to reveal a wound to the outside edge of the right foot. The wound was not covered by a dressing and exposed to the inside of the sock. CNA #10 reached into the resident's sock and removed a dressing. The CNA verified the date written on the dressing was "one fifteen (January 15, 2012)". During an interview in Resident #13's room during the dressing change observation on January 18, 2012 beginning at 2:20 p.m., LPN #2 was asked the stage of the wound. The LPN stated, "...honestly, three (Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss)..." The wound had some yellow streaking in the wound bed and LPN #2 verified the yellow substance as slough (necrotic/avascular tissue in the process of separating from the viable portions of the body and is usually light colored, soft moist and stringy). The LPN measured the wound as 2 centimeters (cm) wide and 2.3 cm long. During an interview in the Atrium Room on January 18, 2012 at 3:20 p.m., LPN #2 was asked to verify the stage of Resident #13's wound while referring to the wound guide used by the facility. The LPN stated the wound was Stage 3. The LPN was asked how often Resident #13 was ordered to have wound care to her right foot wound. LPN #2 stated, "It (wound care) is daily."	F 314		

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F 314	Continued From page 17 During a telephone interview on January 24, 2012 at 9:50 a.m., the wound care physician confirmed that a Stage 2 pressure ulcer could decline in condition to a Stage 3 in a short amount of time if daily treatments were missed. Observation on January 18, 2012 at 2:45 p.m., revealed Resident #13 lying on an air mattress. The air mattress control was set on 200 pounds. During an interview in the resident's room on January 18, 2012 at 2:45 p.m., the air mattress settings were reviewed with LPN #2. LPN #2 verified the air mattress was set for 200 pounds and that Resident #13 did not weigh 200 pounds. Review of the Monthly Resident Assessment dated December 12, 2011 documented Resident #13's weight as 113.8 pounds. During an interview at Nurses Station 1 on January 20, 2012 at 8:00 a.m., Resident #13's Treatment Record for January 2012 was reviewed with the Assistant Director of Nursing (ADON) and verified there was no documentation the wound treatment and dressing change was completed on January 12 or January 17, 2012. The ADON was asked if Resident #13 was care planned for heel protectors. The ADON reviewed the care plan and confirmed there was an intervention for heel protectors when in bed. The surveyor informed the ADON that there were no heel protectors in place when the resident was observed in bed on January 18, 2012. The ADON reviewed Resident #13's chart and stated, "It looks to me like they were ordered in October (2011) and did not get transferred over to the November (2011) treatment sheet..." When asked how air mattress settings were determined,	F 314		

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F 314	Continued From page 18 the ADON stated, "(Named medical equipment provider) comes in and sets the weight on that." When asked if the controls were monitored to ensure the proper setting, the ADON stated, "No." The surveyor asked what the impact would be if the air mattress setting was not at the correct weight or firmness for a particular resident, and the ADON stated, "It (the mattress) would be too firm (to provide pressure relieving)." The ADON confirmed the facility did not have a policy for monitoring air mattresses to maintain the settings. Review of the "ADMISSION AND WEEKLY SKIN ASSESSMENT" dated January 18, 2012 was signed as completed by Registered Nurse (RN) #1. The location of the wound identified as "...® foot / outer arch." The Stage of the wound was documented as "Stage II" and the size was documented as "Length 1.8...Width 2.4...Depth 0.5". During an interview at Nurses Station 2 on January 19, 2012 at 9:15 a.m., RN #1 was asked if completed the wound care for Resident #13. RN #1 stated, "No." RN #1 was asked if completed the weekly skin assessment for Resident #13. RN #1 stated, "No." When the weekly skin assessment dated January 18, 2012 was reviewed, RN #1 verified documenting the skin assessment with the wound stage and measurements. When asked if the wound was visualized, RN#1 stated, "No." RN #1 confirmed the information was obtained from the wound care nurse and the doctor. Review of the Treatment Record for Resident #13 for January 2012 documented wound	F 314		

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F 314	Continued From page 19 measurements "...1-15 (January 15, 2012) area ® foot 1.8 X (by) 2.4 cm..." There was no depth measurement documented. These were the same measurements documented January 18, 2012 on the weekly assessment by RN#1. The actual wound measurements completed by LPN #2 and observed by the Surveyor on January 18, 2012 were 2.0 X 2.3 with no depth measurement taken and the wound was assessed as Stage 3. During an interview in the Atrium Room on January 20, 2012 at 9:50 a.m., RN #1 was asked to review Resident #13's weekly skin assessment completed on January 18, 2012 and asked if RN#1 visualized the wound for this assessment. RN #1 stated went in the room with LPN #2 and watched during the wound treatment and dressing change. The surveyor told RN #1 that the surveyor was in the room with LPN #2 observing the wound care and observed the measurement and staging at that time and that RN#1 was not present in the room. RN#1 stated opened Resident #13's room door and closed the door and left when saw surveyor in the room. The wound measurements documented on the Weekly Skin Assessment completed January 18, 2012 by RN #1 were not the wound measurements or wound staging completed by LPN #2 on January 18, 2012. The facility's failure to ensure the consistent implementation of heel protectors, failure to provide a pressure relieving mattress at the appropriate firmness for Resident #13's weight, failure to provide wound treatment daily as ordered and failure to ensure accurate weekly skin assessments resulted in HARM to Resident #13 when the right foot wound declined from a	F 314		

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F 314	Continued From page 20 Stage 2 to a Stage 3 wound. Resident #3 was re-admitted to the facility on October 20, 2011, following repair of Right Femur Fracture, with diagnoses including Dementia, Diabetes Mellitus Type II (DM II), Osteoporosis, and Right Femur Fracture. Medical record review of the Minimum Data Set (MDS) dated November 16, 2011, revealed the resident required total assistance with transfers and locomotion on the unit; did not ambulate; had limited range of motion with one lower extremity; did not have any pressure ulcers and was at risk for developing pressure ulcers. Medical record review of the Care Area Assessment (CAAs) dated November 16, 2011, revealed, "...All information can be found in the residents chart dated 11/16/2011... " Medical record review of the Care Plan dated November 16, 2011, and last reviewed December 5, 2011, revealed, "...Resident has diabetic condition...Monitor feet closely for redness, breakdown, long toenails, etc (et cetera)...Resident has episodes of Pruritis (itching)...Resident is at risk for skin breakdown related to impaired mobility related to right hip fracture...Assess skin Q (every) week...Document on Skin Assessment..." Medical record review of the Interdisciplinary Notes dated December 14, 2011, at 11:30 p.m., revealed the resident was sent to the hospital for evaluation and treatment of mental status	F 314		

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F 314	Continued From page 21 changes. Medical record review of the Physician Admission Orders dated January 2, 2012, revealed, "...Diagnosis: UTI (Urinary Tract Infection), DM II, HTN (Hypertension), Blind, Anemia, Dementia...Admitted to (named hospital) 12/15/11 (with) AMS (Altered Mental Status). Found to have UTI E. Coli (Escherichia coli), Pseudo A (Pseudomonas aeruginosa) UTI. Treated (with) Doripenem (antibiotic) & (and) finished IV ABX (intravenous antibiotics) on 1/1/12...Waffle boots both feet..." Medical record review of the Resident Assessment Mandatory Hospital Return Form dated January 2, 2012, revealed the resident returned to the facility with non-weight bearing status; dependent on staff for bed mobility, transfer, dressing, toileting, and bathing; occasionally incontinent of bowel; and the skin assessment indicated the resident had pinpoint open areas to both upper thighs, open area and redness to the upper left back, surgical scar to right hip, and bruising to both arms. Medical record review of the Admission and Weekly Skin Assessment dated January 4, 2012, and signed by Registered Nurse (RN) #1, revealed the resident had a rash and redness under the breasts, and folds of skin, and no other skin problems noted. Medical record review of the Admission and Weekly Skin Assessment dated January 11, and 18, 2012, and signed by RN #1, revealed the skin was intact and no skin problems were identified.	F 314		

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F 314	Continued From page 22 Interviews with Licensed Practical Nurse (LPN) #3 on January 18, 2012, at 12:35 p.m., in the elevator, and 1:25 p.m., in the station 3 hallway, and with the MDS Coordinator at 3:05 p.m., in the Atrium, confirmed the resident was independent with most activities and cognitively intact before fracturing the right hip in October, 2011. Further interviews confirmed the resident had been declining in medical condition and abilities with the hip fracture, recurrent UTIs, decreased mobility, and an approximate two week hospitalization. Observation of the resident and interviews with Certified Nursing Assistants (CNAs) #12 and #13 on January 18, 2012, at 3:50 p.m., in the resident's room, revealed the resident was lying in bed with waffle boots on, and both heels protruding through the opening in the boots with the heels lying on the mattress. Further observation and interviews confirmed the resident had a large red and purple area on the right heel which both CNAs thought had "probably" been there, but did not know how long. Further interviews confirmed, since fracturing the hip, the resident was no longer able to stand or walk due to contracted legs, and the resident's condition had declined. Observation and interview with LPN #2, completing a skin assessment for the resident, on January 19, 2012, at 9:55 a.m., in the resident's room, confirmed RN #1 was responsible for completing weekly skin assessments on all the residents. Continued observation and interview confirmed the resident had multiple areas on the legs, arms, and back which were dry and "pinpoint scabbed" areas where the resident	F 314		

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F 314	Continued From page 23 scratched and was not a new condition; had dry, pink, red areas to the buttocks, and a reddened area to the right gluteal fold. Continued observation and interview with LPN #2 confirmed the right heel had a 3.0 cm (centimeter) by 3.8 cm area to the right heel, described as a black and purple area with another area which was a smaller dark purple, raised area measuring 1.1 cm x 0.9 cm, and the tissue surrounding the heel area was "mushy...pink and red..." Further interview confirmed the resident had an unstageable pressure ulcer on the right heel which had not been identified or reported. Interview with RN #1 on January 19, 2012, at 12:50 p.m., at Nursing Station 2, confirmed the RN had documented weekly skin assessments on the resident. Further interview confirmed the weekly skin assessment documented January 18, 2012, did not reflect the multiple areas where the resident had caused scratched and scabbed areas, which were present when RN #1 completed the skin assessment, and the assessment was inaccurately documented. Further interview confirmed RN #1 did not look at the resident's heels on January 18, 2012, failed to notice the unstageable pressure area to the right heel, and did not perform a complete skin assessment. Interviews with the MDS coordinator on January 19, 2012, at 2:30 p.m., Registered Nurse (RN) #5 at 3:15 p.m., the Assistant Director of Nursing (ADON) at 4:10 p.m., and the Director of Nursing (DON) at 5:00 p.m., in the Atrium, confirmed the facility assessed risk factors for developing pressure ulcers using the Braden scale with a resident's first admission and did not complete	F 314		

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F 314	Continued From page 24 any other assessment for pressure ulcer risk except the MDS assessments (resident #3's last MDS assessment was dated November 16, 2011). Further interviews confirmed RN #1 was expected to complete weekly skin assessments on all residents and the skin assessments were to be a complete "head to toe" examination of the resident's skin. Further interviews confirmed all skin abnormalities were to be documented on the weekly skin assessment, treatment initiated, and the charge nurse, physician or nurse practitioner, and family were to be notified immediately of any new pressure ulcer development. Medical record review and interview with the ADON on January 20, 2012, at 8:40 a.m., in the Atrium, confirmed resident #3 had a two week hospitalization, development of new medical conditions, and had experienced a significant decline in condition since admission and the Braden risk assessment in 2008, and the last MDS assessment was completed November 16, 2011. Further interview confirmed when the resident returned to the facility following the hospitalization January 2, 2012, no assessment had been completed to identify the resident's new risk factors for developing pressure ulcers; the resident's care plan had not been updated with new interventions to prevent development of pressure ulcers based on the resident's new risk factors; and the resident had developed an unstageable pressure ulcer to the right heel. The facility's failure to reassess pressure ulcer risk and provide accurate and complete weekly skin assessments resulted in HARM to Resident #3 who developed a deep tissue injury to the right heel which was unidentified by the facility when	F 314		

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F 314	Continued From page 25 performing weekly skin assessments. Medical record review for Resident #15 documented an admission date of January 10, 2012 with diagnoses that included Type II Diabetes Mellitus, Nephrotic Syndrome, Renal Failure, Encephalopathy, Anemia, Dementia, Hypertension, Morbid Obesity and a Fall with Hip Fracture (prior to admission). Review of the "INTERDISCIPLINARY NOTES" dated January 10, 2012 documented, "Has decubitus ulcers X (times) 4 on coccyx & buttocks..." Review of the physician's orders signed January 17, 2012 documented, "...Hydrogel to all open areas on buttocks BID (twice a day) & (and) cover (with) 4 X (by) 4's (gauze pads)..." Observation in Resident #15's room on January 19, 2012 at 2:00 p.m., revealed the resident in bed on his back on a pressure relieving mattress set to "firm". CNA #10 and CNA #13 positioned Resident #15 onto his left side for wound care. When the CNAs rolled the resident onto his side and exposed his buttocks, none of the wounds were covered with gauze pads. The wounds were open and exposed to the inside of the adult diaper. During an interview in Resident #15's room on January 19, 2012 at 2:10 p.m., LPN #2 verified the wounds were not covered with dressings. The LPN was asked if Resident #15 was incontinent. She verified the resident was incontinent and stated, "It's frequent BM (bowel movement)." The LPN stated she didn't know	F 314		

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F 314	Continued From page 26 why there was no dressing on the wounds. "It may have come off when they changed him (cleaned after incontinence)." During an interview in the Atrium Room on January 19, 2012 at 4:37 p.m. the ADON was asked what was expected if a dressing came off a wound that was to be covered. She stated, "...you do a new treatment...If the CNA sees this, then they tell the charge nurse...charge nurse's responsibility to replace (the dressing)" During an interview in the Atrium Room on January 19, 2012 beginning at 5:00 p.m., the Director of Nursing (DON) was asked what was expected if the dressing came off a wound that was to be covered. The DON stated, "...immediately redress by charge nurse...CNA notifies charge nurse..." Resident #16 was admitted to the facility on April 26, 2010, and readmitted on October 29, 2011, with diagnoses including Myocardial Infarction, Alzheimer's Disease, Hypertension, Diabetes Mellitus Type 2, Senile Dementia, and Anxiety. Medical record review of a Weekly Skin Assessment dated January 4, 2012, revealed "...coccyx area...Stage II...1.5 cm width...1.5 cm length...0.2 cm depth...no odor...no drainage..." Observation on January 19, 2012, with two CNA's providing perineal care revealed a Stage II Pressure ulcer on the resident's coccyx and the resident lying on a low air loss mattress.	F 314		

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F 314	Continued From page 27 Continued observation revealed the weight set at 280 pounds. Observation and interview on January 19, 2012, at 4:00 p.m., in the resident's room; with LPN #7 confirmed the resident lying on a Low Air Loss specialty mattress with the weight set at 280 pounds and turned off. Interview with LPN #7 confirmed the resident's current weight as 197.8 pounds. Observation and interview with the ADON on January 20, 2012, at 9:00 a.m., in the resident's room confirmed the Low Air Loss specialty mattress was turned on and set at 280 pounds and confirmed the resident's current weight at 197.8 pounds. Continued interview with the ADON confirmed the specialty mattresses are brought in by an outside company and set up and staff had not "to my knowledge" been inserviced on the importance of the settings of the specialty mattress and for this resident "the higher weight setting would make the mattress firmer." Resident #17 was admitted to the facility on July 18, 2008, and readmitted after a hospital stay on January 27, 2011, with diagnoses including Dementia with Behavioral Disturbances, Depressive Disorder, Senile Dementia, Anemia, Venous Thrombosis, Osteoporosis, Hypertension, and Chronic Kidney Disease. Medical record review revealed the resident was admitted to Hospice care on May 19, 2011, for diagnosis of Severe Progressive Dementia. Medical record review of a Braden Scale For Reducing Pressure Ulcer Risk dated July 18,	F 314		

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F 314	Continued From page 28 2008, revealed a score of 23 (16 or less is considered high risk). Medical record review revealed no other risk assessments for pressure ulcers had been completed since the resident's admission to the facility on July 18, 2008. Medical record review of a Weekly Skin Assessment completed by LPN #2 (Wound Care Nurse) dated November 16, 2011, revealed "...small open area to buttocks...Dermagran to area on buttock q (every) day et (and) PRN (as needed) until healed...Progress: healing..." Medical record review revealed no documentation of the stage, size, or the color of the open area. Medical record review of a Weekly Skin Assessment completed by LPN #2 dated November 23, 2011, revealed "...closed but still red..." Medical record review revealed no documentation of the stage or size of the area. Medical record review of a Weekly Skin Assessment completed by RN #1 (Registered Nurse) dated November 30, 2011, revealed "...coccyx...Stage I...no odor...red...no drainage..." Medical record review revealed no documentation of the size of the area. Medical record review of a Weekly Skin Assessment completed by RN #1 dated December 7, 2011, revealed "...Coccyx...Stage I...no odor...red...no drainage..." Medical record review revealed no documentation of the size of the area. Medical record review of a Weekly Skin Assessment completed by RN #1 dated December 14, 2011, revealed "...buttocks...Stage	F 314		

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F 314	Continued From page 29 I...no odor...red..." Medical record review revealed no documentation of the size of the area. Medical record review of a Weekly Skin Assessment completed by RN #1 dated December 21, 2011, revealed "...buttocks...Stage II...no odor...redden (misspelled)...length 2 cm...width 2 cm...drainage...none at present..." Medical record review of a Weekly Skin Assessment completed by RN #1 dated December 28, 2011, revealed "...Coccyx...Stage I...no odor...redden (misppelled)..." Medical record review revealed no documentation of the size of the area. Medical record review of a Weekly Skin Assessment completed by RN #1 dated January 4, 2012, revealed "...coccyx...stage II...no odor...red..." Medical record review revealed no documentation of the size of the area. Medical record review of a Weekly Skin Assessment completed by RN #1 dated January 11, 2012, revealed "...coccyx Stage I...red,..no odor..." Medical record review revealed no documentation of the size of the area. Medical record review of a Nurse's Note dated January 16, 2012, revealed "...Stage 2 to coccyx is clean/dry..." Medical record review of two Hospice CNA notes dated January 17, 2012, revealed "...bottom is worse...reported to (name) LPN..." Medical record review of the Weekly Skin Assessments and the Nurse's Notes for January 17, 2012,	F 314		

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F 314	Continued From page 30 revealed no documentation of an assessment of the area or of the Primary Physician being notified of the decline of the pressure area. Medical record review of a Weekly Skin Assessment completed by RN #1 dated January 18, 2012, revealed "...Coccyx Stage I...no odor...redden (misspelled)..." Medical record review of the Weekly Skin Assessment revealed no documentation of the size of the wound. Observation on January 19, 2012, at 7:40 a.m., with two Hospice CNA's revealed the resident in bed on a specialty mattress and the two Hospice CNA's providing a bath. Continued observation revealed an unstageable pressure ulcer on the coccyx surrounded by a red area. Interview with the Hospice CNA's at the time of the observation revealed the area had been reported to (name) LPN (#3) on January 17, 2012. Observation and interview on January 19, 2012, at 8:00 a.m., with LPN #2 (Wound Care Nurse) in the resident's room confirmed the pressure ulcer on the coccyx had declined. Continued observation and interview with LPN #2 confirmed an oblong blue to purplish colored area approximately 4.5 cm in size was unstageable and was surrounded by a red area approximately 6 cm in diameter. Continued observation and interview confirmed LPN #2 was unaware of the change in the pressure ulcer and was unsure how to measure the unstageable pressure ulcer. Interview with LPN #3 on January 20, 2012, at 8:00 a.m., at Nursing Station #3 confirmed the Hospice CNAs had reported the worsening wound to LPN #3 and confirmed LPN #3 had	F 314		

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F 314	Continued From page 31 failed to notify the Primary Physician or the FNP (Family Nurse Ptactioner). Interview with the ADON on January 20, 2012, at 8:55 a.m., in the Atrium confirmed LPN #3 had failed to notify the Primary Physician or the FNP of the worsening pressure ulcer. Interview with RN #1 on January 20, 2012, at 9:50 a.m., in the Atrium confirmed RN #1 completes the Weekly Skin Assessments by observation of the residents skin when CNAs take the residents to the shower and "if they have a wound I get the measurements from the nurse doing the treatment." Interview with RN #1 confirmed RN #1 was unaware the Hospice CNA's had reported to LPN #3 the pressure ulcer had declined on January 17, 2012, and had completed the Weekly Skin Assessment on January 18, 2012, by viewing the pressure ulcer without cleaning the current treatment (a thick white ointment) from the wound to allow accurate visualization. Continued interview with RN #1 confirmed the description of the pressure ulcer as unstageable and confirmed the assessment completed on January 18, 2012, identifying the pressure as a Stage I was inaccurate.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F - 323 The corrective actions that will be accomplished for the resident #3 who was found to be affected by the deficient practice is as follows: The personal safety device was attached on 1-18-2012 and will be attached at all time when the resident is in bed and the bilateral fall mats will be on the floor when the resident is in the bed, The LPN/Charge has the responsibility to see that they are in place through the MAR check off q Shift. The Nursing staff will bae inservicead 2-9-2012 by the Asst. Don on	

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F 323	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place to prevent falls for one resident (#3) of five residents with falls reviewed. The findings included: Resident #3 was re-admitted to the facility on October 20, 2011, following repair of Right Femur Fracture, with diagnoses including Dementia, Diabetes Mellitus Type II (DM II), Osteoporosis, and Right Femur Fracture. Medical record review of the Minimum Data Set (MDS) dated November 16, 2011, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15 (no cognitive impairment); required total assistance with transfers and locomotion on the unit; did not ambulate; had limited range of motion with one lower extremity; and had a history of falls. Medical record review of the Care Plan dated November 16, 2011, last reviewed December 5, 2011, revealed an update dated December 12, 2011, "PSA (Personal Safety Alarm) in bed and chair...Resident slid out of bed. No injuries noted..." Medical record review of the Interdisciplinary Notes for December 12, 2011, revealed, "...6:45 A (a.m.)...resident sitting in floor beside bed, stated...turned over in the bed & (and) slid out on floor on buttocks...PSA applied for bed & chair...10:45 pm. Resident noted on floor beside	F 323	personal safety devices. To identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken the facility will: all residents who currently have personal safety devices have been care planed checked by the MDS Coordinator on 1-30-2012 and were checked on 1-20-2012 to see that they were in place, and the specific device is listed on the resident's MAR. The LPN/Charge Nurse must check this off the MAR daily as being in place correctly. There is also a current list at each nurses Station of any resident on that hall who requires a personal safety device for any Nursing staff to be aware of. The Asst. DON will have an inservice on 2-9-2012 with the Nursing Staff on the importance of monitoring these personal safety devices. The Restraint Committee, MDS Coordinator, Nursing Secretary and Restortative Aide, keeps a list up to date at each Nurses Station which is updated on Wednesday of each by the Nursing Secretary and if any changes occur between that time the LPN/Charge Nurse or the MDS Coordinator will up date of any new or changes, of which resident on that hall requires a personal safety device keeping staff up to date at all times. The LPN/Charge Nurse will have the responsibility of checking for the attachment of these personal safety devices through a check off on the MAR q Shift. The MAR is also updated with the current personal safety device and changes are made during the month if necessary and transferred to the next month MAR to keep the Nursing Staff	

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F 323	Continued From page 33 of...bed...states...tried to roll over & slid out of bed. No injuries found...this nurse & CNA (Certified Nursing Assistant) removed air mattress from bed & replaced (with) regular mattress..." Medical record review of the Interdisciplinary Notes revealed the resident had no injuries from the falls. Medical record review of the Alarms and Devices Order Form 2012 signed by the physician January 2, 2012, revealed the resident was to have a Chair Alarm (PSA) and PSA in bed, and both alarms had been ordered December 12, 2011. Observation of the resident on January 17, 2012, at 6:30 p.m., in the resident's room, revealed the resident sleeping in bed with the PSA attached and a fall mat on the floor on the resident's right side of bed. Observation of the resident on January 18, 2012, at 7:45 a.m., in the resident's room, revealed the resident sleeping in bed, the PSA not attached, and a fall mat on the floor next to the resident's right side of bed. Observation of the resident on January 18, 2012, at 8:15 a.m., in the resident's room, revealed the resident in bed sleeping, the PSA attached, and fall mats on the floor on both sides of the resident's bed. Interview with CNA #12 on January 18, 2012, at 8:25 a.m., in the Station 3 hallway, confirmed the resident was to have the PSA at all times and bilateral fall mats when in bed. Continued interview confirmed the PSA was not attached	F 323	up to date with any resident requiring a personal safety device. Both of these communications will ensure that the deficient practice does not recur. The Asst DON will audit the MAR monthly (starting 2-10-2012, for the signing off by the Charge Nurse/LPN for the use and proper attachment of any personal safety device. This monthly audit will come to the DON and Administration to present to the QA for recommendations if we are finding these personal safety devices are not being used and monitored to prevent falls. This information will be taken to the Quarterly QA(Medical Director, DON, Asst. Don and Adm) by the Asst. DON to see if the Medical Director has any suggestions or information that might help this from reoccurring.	F323 2-10-12

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F 323	Continued From page 34 when the CNA went to the room after breakfast and only one fall mat was down. Interview with the MDS Coordinator on January 18, 2012, at 3:05 p.m., in the Atrium, confirmed the resident had two falls on December 12, 2011, and interventions to prevent further falls of a PSA at all times and bilateral fall mats when in bed, were to be used.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observations and interview the facility failed to ensure staff provided encouragement and assistance with feeding for two (#7, #4) with weight loss, of eight residents reviewed for weight loss. The findings included: Medical record review revealed resident #7 was admitted from the hospital to the facility on	F 325	F - 325 The corrective action that will be accomplished for resident #7 is: he will be given encouragement and assistance with feeding by the staff. The Nursing staff will be given an inservice on 2-9-2012(mailing information to all who do not attend) stressing the importance on feeding techniques, feeding guidelines and accurate recording of meal intake by the Asst DON. Resident #4 passed away on 1-26-2012. To identify other residents that might have the potential to be affected by the same deficient practice; our nursing staff are always observant of residents eating habits and report any changes to their Supervisor to have them evaluate the resident by looking at the weight loss documentation. They daily intake sheets are audited daily, this has always been our procedure, by the Dietary Manager reporting any residents that aren't eating to the DON to discuss any interventions that could be taken. As the Dietary Manager and the RD go over the weekly and monthly weights, these are audited twice a month of by phone if a resident loosse weight inbetween times, they will identify residents at risk and will take corrective actions by either adding nutritional supplements or appetite	

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F 325	Continued From page 35 September 8, 2011. Review of a facility assessment dated September 21, 2011 revealed diagnoses of Diabetes, Cardiac Dysrhythmia, Hypertension, Dysphagia (difficulty swallowing), Vitamin D Deficiency, Muscle Weakness, Pacemaker, and Difficulty Walking. The assessment dated September 21, 2011 also revealed the resident was oriented only to self, was easily distracted, mental function varies over the course of the day, was some times understood and rarely/never understands. The Acitvities of Daily Living (ADL) Support Performance on the assessment indicated the resident required a one person physical assist with eating. Review of an Initial Nutritional Assessment dated September 14, 2011 by the Certified Dietary Manager (CDM) and signed by the Registered Dietician (RD) on September 22, 2011 revealed the resident weighed 196.6 pounds when admitted and an ideal body weight of 148 plus/minus 10 percent. On September 14, 2011 the CDM also completed a Malnutrition Risk Assessment and scored the resident at an eleven, with a total score above ten representing a HIGH RISK for malnutrition. Review of the dietary progress notes dated September 29, 2011 revealed the resident's diet was changed from a pureed to a mechanical soft and the resident was placed on 1:1 (One to One) Feeding Guidelines. Review of a dietary progress note dated December 6, 2011 revealed "Due to a 23 # (pound) wt. (weight) loss last qtr (quarter) Pt. (patient) will receive milk shake at dinner with meals. Med pass (nutritional drink) T.I.D. (three times per day) Monitoring acceptance."	F 325	stimulant, putting them on weekly weights, and discussing the resident with Nursing to get Medical intervention. The DON reviews weights daily, weekly and monthly and is responsible,for any resident who shows the potential to be at risk and is to take the proper measures to see that every intervention is taken to prevent the weight loss from occurring. As Speech Therapy and Occupational Therapy do assessments of residents at risk and their recommendations come through to the Feeding staff, the instructions will be printed on the CNA's flow sheets and on special tray card with this information so they can follow through with these instructions. The Asst. DON will inservice on 2-9-2012 CNA staff on the importance of properly recording intake, encouragement, offering substitutions, and being able to interpret feeding guide lines on their flow sheets and in reading a special tray card. This information will appear also in the orientation check sheet for every new Nursing Staff employee. The daily intake sheets are being currently reviewed by the Dietary Manager on a daily basis and the RD and Dietary Manager will begin a bi monthly review basis, starting with the February visit from the RD, to compare this with the weekly and monthly weights to see if any residents should be added to weekly monitoring and if any dietary supplements should be given or reporting to the Nursing Department for Medical interventions to try to ensure that the deficient practice does not recur. The Asst. DON will monitor through a Dining Room Observation Report that she will use weekly with actually viewing all three meals, starting 2-13-2012, and will continue	

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F 325	Continued From page 36 Review of the Feeding Guidelines dated September 29, 2011 revealed the following interventions: Assistance Level: Tray set up and supervision 1:1 (one to one), verbally cue patient to put spoon down between bites, elevate upper body to at least 90 degrees for all oral intake, reduce distractions, encourage small, control sips (avoid gulping or sequential sips), offer liquids every 2 to 3 bites, alternate food bites/liquid sips, ask patient to clear throat or cough when voice sounds "wet or gurgle", maintain upright upper body position for at least 30 minutes after eating. Review of the facility policy Meal Substitutions updated on September 19, 2011 revealed: Procedures: 1. For any resident consuming 75 percent or less of any meals, a substitute will be offered. 2. If the substitution is refused; an attempt will be made to fulfill the residents request for a meal substitution. Observation on January 17, 2012 at 5:10 p.m. revealed resident #7 was seated in a wheel chair at a restorative dining table with five other residents. The resident continuously attempted to roll self away from the table. At 5:15 p.m. Certified Nursing Assistant (CNA) #1 set the dinner meal in front of the resident and offered the resident "a bite" of food. The resident said "not hungry." At 5:17 p.m. the resident slowly rolled self, by scooting the feet, out of the dining room. Observations revealed there were no more attempts to feed or encourage the resident to eat or drink and no substitutions were offered. There were no attempts by any staff to bring the resident back to the table. The resident wheeled self to own room.	F 325	for six months, alternating meals and times and days of the week, in the course of a week seeing that residents are encouraged, serving one table at one time, offering substitutes, calculating meal intake correctly, sitting facing residents, changing clothing protectors, distracting agitated residents and how they are following compensatory strategies or feeding guidelines. This report will go to the ADM and DON at monthly QA(Adm, DON and Asst. DON) and an audit will determine if any changes or education needs to be made or done, this will begin 2-12-2012. Weights are discussed at the quarterly QA of which the Medical Director is in attendance and he will give any suggestions if he feels that there is anything else that could be done to prevent this from reoccurring.	F 325 2-10-12

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F 325	Continued From page 37 Review of the meal and fluid intake chart for recording food and fluid intake for January 17, 2012, dinner meal revealed the resident was recorded as, "Refused dinner, liquids and supplement." Observation on January 18, 2012 at 7:06 a.m. revealed resident #7 was seated in a wheelchair at a restorative dining table with six other residents. At 7:26 a.m. a CNA served the breakfast meal to the resident, removed the plate cover and walked away to get another resident's tray. The resident was observed to push back from the table. At 7:35 a.m. a CNA said to the resident "You going to eat breakfast?" The resident replied, "No, am not." The resident continued to wheel self out of the dining room. Observations at 7:35 a.m. revealed there were no attempts by staff to feed or encourage the resident to eat, no substitutions offered, and no attempts by any staff to bring resident back to the dining room. At 7:45 a.m. the resident was observed in own room attempting to remove jacket and put self to bed. At 7:50 a.m. Registered Nurse (RN) #1 was requested to have staff weigh the resident. Observation on January 18, 2012 at 8:00 a.m. revealed RN #1 pushing the resident in a wheelchair, taking resident back to the dining room. The RN gave the resident a bowl of cereal and attempted to encourage the resident to eat. Observation at 8:12 a.m. revealed a CNA sitting beside the resident at the restorative table attempting to feed cereal to the resident. At 8:15 a.m. the CNA got up and said "Resident ate a couple bites." The resident was then taken back	F 325		

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F 325	Continued From page 38 to the room. Review of the meal and fluid intake chart for January 18, 2012 breakfast meal revealed the resident was recorded as a "3", indicating 51-75 percent of the meal was eaten. Interview on January 18, 2012 at 2:00 p.m. at the Atrium door with the House CNA, who records the intake percent on the Resident Care Flow Record taken from the meal tickets delivered with the meal tray and where the CNAs assisting the resident records the food percentage eaten, and the CNA who assisted the resident at breakfast, revealed the "3" was probably a recording error. The CNA said "Would say zero, ate only two bites." Interview with RN #1 on January 18, 2012 at 2:05 p.m., at Station #2, revealed, "No way ate "3" (51-75%) at breakfast. Didn't eat anything, that's why (I) took (resident) back and gave cereal." The Meal and Fluid Intake Chart was corrected to say refused the January 18, 2012 breakfast meal. Review of the Resident Care Flow Record where the monthly meal intakes are recorded revealed on January 18, 2012 the resident had refused the dinner meal. Observation on January 19, 2012 at 7:45 a.m. revealed resident #7 in the dining room at the restorative table, with five other residents. The resident was being assisted by CNA #6. On the resident's tray, as also observed at all other meal observations for this resident, was a dietary card stating 1:1 Feeding Guidelines. Another resident at this same table and being assisted by another CNA also had a dietary card stating 1:1 Feeding Guidelines. Observation at 8:00 a.m. revealed four CNAs (#6, #7, #8, #9), at this table assisting	F 325		

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F 325	Continued From page 39 residents, and one CNA (#10) at a surrounding table also feeding a resident. All five CNAs were interviewed as to what 1:1 Feeding Guidelines were. Four stated they did not know, one stated it meant one person feeding one person, and the other CNA agreed with one person feeding one person. This CNA then changed and said it meant one CNA can feed two residents. Review of resident #7's meal ticket delivered with each tray and where the assisting CNA records percentages eaten, revealed on the bottom of the ticket written in dark print "Special Note FEEDING GUIDELINES". Interview on January 19, 2012 at 8:30 a.m. at Nurse Station #2 with the Assistant Director of Nurses (ADON) revealed the facility does not provide CNA training for accurately recording percentages of food intake. The ADON stated, "Would hope got in CNA classes." The ADON stated she "caught as many CNAs as could" for an in-service on 1:1 Feeding Guidelines which was "probably given on September 29, 2011, but not sure". Review of the in-service provided by the ADON, revealed nine CNA names with no date or time given. The ADON stated no other in-service for the 1:1 Feeding Guidelines had been given. When interviewed related to changes in feeding instructions and if the nurses would alert the CNAs to the changes, the ADON stated, "Probably not, the nurses put it in the CNA book and it is the CNAs responsibility to see it." Review of the employee roster provided by the facility revealed thirty-five CNAs are employed. Review of the January, 2012 weight record for resident # 7 revealed weights of: January 2, 2012	F 325		

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F 325	Continued From page 40 = 178.6, January 10, 2012 = 173.0, January 17, 2012 = 173.0. On January 19, 2012, at the request of the surveyor, the resident was weighed. The Rehab CNA weighed the resident and the weight was 171.4, a 4 percent weight loss in seventeen days. Interview on January 18, 2012 at 1:30 p.m. with the Director of Nurses (DON) and the Minimum Data Set Coordinator, in the DON's office confirmed the CNAs are to encourage, assist, offer substitutions, and prevent the residents from leaving the dining room table without eating until all approaches have been attempted. Medical record review revealed resident #4 was admitted to the facility on December 21, 2011 with diagnoses of Alcohol and Tobacco Use Disorder, Organic Brain Syndrome, Seizures, Glaucoma with Blindness, and Metastatic Lung Cancer. Review of a facility Nursing Admission Assessment dated December 21, 2011 revealed the resident had weakness and periods of confusion and forgetfulness. The resident was receiving Hospice services. Review of an Initial Nutritional Assessment dated December 22, 2011 by the CDM and signed by the RD on January 6, 2012 revealed an admission weight of 117.8 pounds with an ideal body weight of 160 pounds. The resident is severely underweight. The assessment identified the resident as needing assistance with meals. The CDM, on December 22, 2011 also completed a Malnutrition Risk Assessment and scored the resident at a thirteen, with a total score above ten representing a HIGH RISK for malnutrition. The resident was on a regular mechanical soft diet	F 325		

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F 325	Continued From page 41 with milkshakes with each meal. Review of the plan of care for resident #4, updated on January 10, 2012, revealed approaches of verbally "map" location of foods on tray for resident related to being blind and assist with all activities of daily living resident was unable to self-perform. Observation on January 18, 2012 at 12:35 p.m. revealed resident #4 was brought into the dining room. The resident was seated in a wheelchair with a lap and pommel cushion. At 12:40 p.m. CNA #5 served and removed the cover from the lunch meal. The CNA sat next to the resident and started to feed the resident. The resident said, "Needed to lie down." The CNA said, "have a few bites and can then lay down." The CNA was observed to give the resident two bites of food then get up and walk to another table. At 12:45 p.m. the CNA returned and said "Are you all done eating, you ate a couple bites." The CNA left the resident and returned at 12:47 p.m. and gave the resident a glass of water and then took the lunch tray away. The CNA was interviewed as to how much the resident ate and the CNA said "Would give the resident a "1" (25% for food intake), and drank some." Observation at 12:48 p.m. revealed the CNA wheeled the resident out of the dining room. The resident was not instructed about location of foods on plate, was not offered substitutions for food not eaten and no encouragement was given to eat. At 12:50 p.m. on January 18, 2012 RN #1 was asked to look at the meal tray of resident #4. The tray was in a cart in the dining room where dirty/finished trays were placed. The RN said she	F 325		

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	44A120	A. BUILDING _____ B. WING _____	C 01/20/2012

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F 325	Continued From page 42 would score the meal intake percent as zero, not a one (25 percent). The RN said all the milk and milkshake were on the tray, all beans and bread untouched, and maybe a bite of potatoes and apples had been given. Review of the January 2012 weights revealed one weight for January 2, 2012 which was recorded as 119.2 pounds. The resident was weighed on January 19, 2012 at the request of the surveyor, and the weight was 115.5 pounds, a loss of 3.7 pounds since January 2, 2012. Interview with the Minimum Data Set (MDS) Nurse on January 20, 2012 at 10:05 a.m. outside the DON's office, related to the resident's weight loss and if the resident is to be weighed every week, revealed the facility policy is to do weekly weights only if a significant weight loss. The MDS Nurse stated, "Well isn't that to be expected" (weight loss for a Hospice resident). Interview with the Registered Dietician on January 20, 2012 at 10:45 a.m. at Station One revealed "Weekly weights are probably not necessary (for resident #4) but just because on Hospice doesn't mean wouldn't monitor weights and encourage nutritional intake."	F 325		
F 454 SS=K	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observations, fire alarm testing and	F 454	F - 454 To immediately eliminate the Jeopardies the following action was taken and approved: On 1-17-2012 the doors were unlocked and were operable through the key pad system. On 1-18-2012 the outside key pad was disarmed on all the doors and a sign was placed on the doors "Not An Entrance". A memo ws issued to all employees the doors were unlocked and all exits were obtainable through the key pad system with	

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F 454	Continued From page 43 staff interviews, the facility failed to ensure three of eight exit doors used to evacuate residents from the building in case of emergency were operable at all times. The facility's failure resulted in an Immediate Jeopardy (a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). The Immediate Jeopardy for tag F-454 and K-38 was effective January 17, 2012 and removed January 17, 2012 after the facility provided corrective action to ensure safe exit from the facility for three of eight exit doors in case of emergency. The Immediate Jeopardy tags were lowered in scope and severity from a "K" to an "E" level. A partial extended survey was conducted January 17, 2012. The findings included: Refer to the Life Safety Code Survey deficiency K-38.	F 454	a sticker to put on their name badge of the code. Keys are now available to al employees in the building from 10:00 P.M. till 5:00 A.M. to override the system should alarm not unlock these doors. A copy of memo and inserviee sheet was approved by inspector to very all employees had been notified. The inside key lock will be dismantled. The Maintenance Director and the Housekeeping Department check these exit doors daily with a check off sheet to see that they are unlocked and operable through the key pad system and this report goes to the QA monthly for the Safety Committee, consisting of Administrator, DON, Maintenance Director and Housekeeping Supervisor, to determine if there has been any problems with the door being locked at any un approved times and that the door is functioning properly and does not require any repair service.	F454 1-18-12
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents	F 497	F - 497 The corrective actions that will be accomplished the CNA's will be inserviced on 2-9-2012 by the Asst DON on the importance of recording food intake correctly and how to read special feeding guidelines. All residents have the potential to be affected by this deficient practice therefore through the above inservice the CNA's will learn the importance of recording intake correctly and consistently and for being alert when a tray is delivered to read the tray card with feeding guidelines. The Facility will continue to inservice twice a year on Unintended Weight loss in elderly,	

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F 497	Continued From page 44 as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of Certified Nurse Aide (CNA) in-service records and interview, the facility failed to ensure CNAs received training related to accurately recording percentages of food intake and training for 1:1 (one to one) Feeding Guidelines. The findings included: Interview on January 19, 2012 at 8:30 a.m. at Nurses Station #2 with the Assistant Director of Nurses (ADON) revealed the facility does not provide CNA training for accurately recording percentages of food intake. The ADON stated, "Would hope got in CNA classes." The ADON stated she "caught as many CNAs as could" for an in-service on 1:1 Feeding Guidelines which was "probably given on September 29, 2011, but not sure". Review of the in-service provided by the ADON, revealed nine CNA names with no date or time given. The ADON stated no other in-service for the 1:1 Feeding Guidelines had been given. When interviewed related to changes in feeding instructions and if the nurses would alert the CNAs to the changes, the ADON stated, "Probably not, the nurses put it in the CNA book and it is the CNAs responsibility to see it." Review of the employee roster provided by the facility revealed thirty-five CNAs are employed.	F 497	including in it recording food intake correctly and how to read special feeding guidelines. This inservice is given by the dietary Manager in July and December. The Assistant DON will do a weekly audit ,starting 2-13-2012 and will last for 6 months, all three meals on alternating days of the week, of the dining room observing the feeding techniques, Dining Room Observation Report attached) used by the CNA's and will report to the DON and Administrator with the month QA meeting (Adm, Don and Asst. DON) if further education is needed to try to ensure the deficient practice will not recur. The Asst. DON will take these audits to the quarterly QA of which the Medical Director is a member along with the DON, Asst. DON and ADM. for any suggestions he might have to prevent this from reoccurring.	F497 2-9-12

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